ADMINISTRATIVE POLICIES AND PROCEDURES State of Tennessee Department of Correction	Index #: 113.35	Page 1 of 9
	Effective Date: July 15, 2002	
	Distribution: A	
	Supersedes: 113.35 (6/1/00) PCN 00-75 (10/15/00)	
Approved by: Donal Campbell		
Subject: MODIFIED DIETS		

I. AUTHORITY: TCA 4-3-603, TCA 4-3-606.

II. PURPOSE: To provide therapeutic diets for patients whose health condition requires a diet other than that prepared for the general population.

III. APPLICATION: Wardens, health care staff, unit managers, correctional officers, food service managers, inmates and privately managed facilities.

IV. DEFINITIONS:

A. Modified Diet: Special meals or food prescribed by an authorized health care professional as part of the patient's treatment.

B. Authorized Health Care Professional: For purposes of this policy, a physician, dentist, mid-level provider, or registered dietitian.

V. POLICY: Modified diets shall be requested by an authorized health care professional when medically/dentally indicated, and shall be provided by food service staff.

VI. PROCEDURES:

A. Authorization and Indications:

1. Modified diets shall be ordered by an authorized health care professional only when a medical or dental condition precludes the inmate from eating the food prepared for the general population.

2. Modified diets shall not be ordered to accommodate an inmate's food preference or special requests.

3. The institutional physician/designee, in cooperation with the food service manager, should attempt to minimize unnecessary modified diet orders in the institution by educating the inmate in proper self-care and nutrition in lieu of ordering a modified diet. Education should include written materials with emphasis on foods to avoid, foods which are of benefit, and weight management, when appropriate.

4. Health services professionals shall not order modified diets to comply with an inmate's religious beliefs. These inmates shall be referred to the chaplain.

B. Documentation:

In all cases, documentation of the condition requiring a modified diet shall be recorded in the health record. When a modified diet order is required, a Modified Diet Request, CR-1798, shall be initiated by the physician, dentist, or mid-level provider. These diet orders shall be documented on the Physician's Orders, CR-1892.

C. Requests/Orders:

1. The Modified Diet Request, CR-1798, shall include the inmate's name, number, date of birth, institution, housing unit, allergies, and potential food/drug interactions.

2. Diets which are most commonly utilized within the department are specified on CR-1798. The type of request, caloric requirement if appropriate, and the type of diet shall be indicated.

3. The duration of the diet must be indicated and a start and stop date shown. Special instructions shall include any special meals, snack times, etc.

4. Orders are valid for a maximum of three months, or until they expire, are discontinued, are changed by the authorized health care professional, or are refused in writing by the inmate.

5. Diets other than those listed may be utilized as needed on a restricted basis and most commonly will be ordered during periods of inpatient care. Diets may be requested as titled in the Manual of Clinical Dietetics from the American Dietary Association (ADA).

6. If a diet is required which is not included on form CR-1798 (e.g., renal), or if other modifications are needed, the prescriber must contact the food service manager or TDOC Director of Food Services to review these needs.

7. The CR-1798 shall be separated with a copy to the health record, a copy to the inmate, and the original and a copy to the food service department.

8. The modified diet shall begin with the next scheduled meal, unless otherwise indicated. The written request, CR-1798, must be delivered to the food service manager or designee at least two hours prior to the serving time in order to be effective for that meal. (See Policy #116.01 regarding food service responsibilities.)

9. The health service staff shall document service of trays in their respective infirmary wards, to include refusal.

10. The correctional officer who supervises the tray delivery service on any unit with satellite feeding shall be responsible for documenting diet tray service/refusal.

11. When the health care staff encounters patients who are non-compliant with their modified diets they shall counsel the patient regarding the importance and necessity of compliance with the diet. This counseling shall be documented in the health record on the Problem Oriented Progress Record, CR-1884, or Teaching Counseling Plan, CR-2742. Inmates may refuse medical diets by signing a Refusal of Medical Services, CR-1984, according to Policy #113.51. The inmate shall also be charged for the cost of specially prepared meals not picked up. (See Policy #116.01.)

12. When a modified diet request is refused or canceled, the food service department shall be notified per institutional procedure.

D. Dietary Education:

When initiating a new diet, the prescriber shall have the responsibility of explaining to each inmate the nature of his/her diet, the duration, restrictions, special instructions, and recommended commissary restrictions. This educational intervention shall be documented in the inmate health record. The inmate shall then sign CR-1798, indicating that the modified diet has been fully explained.

E. Food Service Responsibilities:

1. The modified diet shall begin with the next scheduled meal unless otherwise indicated. The written request, CR-1798, must be delivered to the food service manager or designee two hours prior to the next meal being served.

2. The food service manager or designee(s) shall maintain a current file system for inmates with modified diet orders.

3. After the diet order has expired, the original of the completed CR-1798 shall be forwarded to the clinic/ward for placement in the health record (to replace verification copy), and the completed copy shall be kept for one year in a permanent file by the food service manager.

4. Modified diets transported to the segregation units shall be handled in a sanitary manner. Trays shall be covered and foods held at their proper temperatures (140EF for hot foods and 40EF for cold foods). Foods shall be plated as near serving time as possible. Service of diet trays shall conform to normal meal service hours and procedures.

5. Diets served in an infirmary shall follow the same procedure as specified in paragraph VI.(E)(4) above and the same sanitary standards shall apply. However, when trays are served on infirmary wards, this service shall be supervised by the person in charge of the unit or the designated health service staff. To ensure trays are served accurately and are consistent with the diet order, the diet menu shall be supplied to the person supervising diet service.

6. Carefully documented records (CR-1798) shall be kept on all diets refused. The food service manager or supervisor shall be responsible for documentation in the dining rooms.

F. Transfers:

1. When an inmate on a modified diet is transferred to another facility, all pertinent information regarding the diet shall be entered in the health record which accompanies the inmate. (See Policy #113.04.)

2. Upon an inmate's transfer, the current and valid diet order shall be included in the record for transfer to the receiving institution. The modified diet shall be continued until the inmate can be reevaluated by a physician, dentist, or mid-level provider at the receiving institution.

VII. ACA STANDARDS: 3-4299.

VIII. EXPIRATION DATE: July 15, 2005.

TENNESSEE DEPARTMENT OF CORRECTION

MODIFIED DIET REQUEST

INSTITUTION: ______________________ **LOCATION:** ______________________

NAME: ______________________ NUMBER: ____________ DATE OF BIRTH: ____________

ALLERGIES: ______________________

POTENTIAL FOOD/DRUG INTERACTION: ______________________

TYPE OF REQUEST: ☐ New ☐ Renewal ☐ Change ☐ Cancel

CALORIE REQUIREMENT: ☐ 1800 ☐ 2000 ☐ 2200 ☐ 2400

TYPE OF DIET:

☐ Clear Liquid - 3 days only ☐ Full Liquid ☐ Other: ______________________

☐ Moderate Sodium Restriction (2000 Mg.) ☐ Low Cholesterol (200 mg.) (28%), Fat Controlled ☐ Mechanical Soft (7 days only)

DURATION: ____________Days START DATE: ____________ STOP DATE: ____________

SPECIAL INSTRUCTIONS (Special Meals, Snacks, etc.): ______________________

SIGNATURE: ______________________ DATE: ____________

Health Care Provider/Title

THIS SPECIAL DIET HAS BEEN EXPLAINED TO ME AND I UNDERSTAND I WILL BE CHARGED THE COST OF ANY MODIFIED MEAL I FAIL TO PICK UP.

______________________ ____________

Inmate's Signature Date

THIS SECTION TO BE COMPLETED BY DIETARY SERVICES

DIETARY SERVICES (Comments compliance/noncompliance, i.e., failure to pick up diet, diet refusal, irregular use, etc.):

Diet Compliance/Noncompliance: (Circle Letter to Indicate Noncompliance)

B = Breakfast **L** = Lunch **D** = Dinner

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

MONTH ______________________

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B	B
L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L	L
D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D

SIGNATURE: ______________________ DATE: ____________

Authorized Food Service Representative/Title

Order Form 1206/4 (If 4-part set) or
Order Form 1206/5 (If 5-part set

PHYSICIAN'S ORDERS

NAME

ROOM NO.
(ADDRESS)

HOSP. NO.

PHYSICIAN

Drug Allergies

Date & Time	Another brand of drug identical in form and content may be dispensed unless checked ☐	DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS → (1)	Nurse's Initials

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ INMATE NUMBER: _____

DATE	TIME/PLACE	PROB NO.	

Do Not Write on Back

TENNESSEE DEPARTMENT OF CORRECTION

TEACHING/COUNSELING PLAN

Patient's Name

Subject

ELEMENT	DATES TAUGHT

Note: Each entry must be signed.

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES

INSTITUTION _____

Date _____ 20 _____ Time _____ AM/PM

This is to certify that I _____, _____
(Inmate's Name) (TDOC Number)
have been advised hat I have been scheduled for the following medical services and/or have been adivsed to have the following evaluations, treatment, or surgical/other procedures:

_____

_____

_____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: _____ _____ _____
(Inmate) (TDOC number) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

The above information has been read and explained to,

_____ _____ but has refused to sign
(Inmate's Name) (TDOC number)
the form.

Witness: _____ _____ _____
(Signature) (Title) (Date)

Witness: _____ _____ _____
(Signature) (Title) (Date)

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POLICY CHANGE NOTICE 03-22

INSTRUCTIONS:

In Section VI.(C)(11), please eliminate the phrase "(See Policy #116.01.)"